Senate Bill No. 454

Passed the Senate August 23, 2001

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Secretary of the Senate

Passed the Assembly July 19, 2001

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of

_____, 2001, at _____ o'clock __M.

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Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 106, 9095, and 10198.6 of the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

SB 454, Committee on Insurance. Insurance.

Existing law defines disability insurance to include insurance appertaining to injury, disablement, or death resulting from accidents or sickness.

This bill would define the term ''health insurance'' as a disability insurance policy that provides coverage for hospital, medical, or surgical benefits but does not include certain kinds of insurance.The bill would also make a related change.

Existing law authorizes secret fraternal societies meeting certain requirements to form insurers by association of their members. Existing law authorizes the association to insure against a specified list of losses, including vandalism or malicious mischief, ice, snow, and freezing, and collapse.

This bill would add to the list of insured losses burglary and theft and mysterious disappearance.

The people of the State of California do enact as follows:

SECTION 1. Section 106 of the Insurance Code is amended to read:

106. (a) Disability insurance includes insurance appertaining to injury, disablement or death resulting to the insured from accidents, and appertaining to disablements resulting to the insured from sickness.

(b) In statutes that become effective on or after January 1, 2002, the term ''health insurance'' for purposes of this code shall mean an individual or group disability insurance policy that provides coverage for hospital, medical, or surgical benefits. The term ''health insurance'' shall not include any of the following kinds of insurance:

(1) Accidental death and accidental death and dismemberment.

(2) Disability insurance, including hospital indemnity, accident only, and specified disease insurance that pays benefits on a fixed benefit, cash payment only basis.

(3) Credit disability, as defined in subdivision (2) of Section 779.2.

(4) Coverage issued as a supplement to liability insurance.

(5) Disability income, as defined in subdivision (i) of Section 799.01.

(6) Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(7) Insurance arising out of a workers' compensation or similar law.

(8) Long-term care.

SEC. 2. Section 9095 of the Insurance Code is amended to read:

9095. An association may, if it has issued an insurance policy against fire, endorse that policy to extend the coverage thereof to include loss or damage caused by windstorm, cyclone, tornado and hail, explosion, riot, riot attending a strike, aircraft, vehicles and smoke, and to include waiver of the fallen building clause. An association may also insure against (a) water damage from plumbing and heating systems, (b) rupture or bursting of steam or hot water heating system, (c) vandalism or malicious mischief, (d) vehicles owned or operated by the insured or by any tenant of the described premises, (e) glass breakage, (f) ice, snow and freezing, (g) fall of trees, (h) collapse, (i) burglary and theft, and (j) mysterious disappearance.

As used in this section ''explosion'' does not include explosions (a) of any boiler, heater, or other fired pressure vessel, caused by pressure of contents, (b) of any unfired pressure vessel or of any piping caused by pressure of contents or vacuum, (c) of any engine, turbine, compressor, pump, or wheel, (d) of any electrical apparatus, or (e) of any other machine having moving or rotating parts. This restricted definition of ''explosion'' does not exclude loss or damage by fire only where fire ensues.

As used in this paragraph, the terms ''boiler,'' ''heater,'' and ''pressure vessel,'' do not include hot water heaters used solely to provide hot water for delivery to faucets for domestic purposes and having a storage capacity of not more than 50 gallons.

SEC. 3. Section 10198.6 of the Insurance Code is amended to read:

10198.6. For purposes of this article:

(a) ''Health benefit plan'' means any group or individual policy or contract that provides medical, hospital, or surgical benefits. The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) ''Late enrollee'' means an eligible employee or dependent who has declined health coverage under a health benefit plan offered through employment or sponsored by an employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health benefit plan of that employer; provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee or dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) The individual was covered under another employer health benefit plan or no share-of-cost Medi-Cal coverage at the time the individual was eligible to enroll.

(B) The individual certified, at the time of the initial enrollment that coverage under another employer health benefit plan or no share-of-cost Medi-Cal coverage was the reason for declining enrollment provided that, if the individual was covered under another employer health benefit plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) The individual has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment

status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of a person through whom the individual was covered as a dependent, legal separation, divorce, or loss of no share-of-cost Medi-Cal coverage.

(D) The individual requests enrollment within 30 days after termination of coverage, or cessation of employer contribution toward coverage provided under another employer health benefit plan.

(2) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan.

(4) The carrier cannot produce a written statement from the employer stating that, prior to declining coverage, the individual or the person through whom the individual was eligible to be covered as a dependent was provided with, and signed acknowledgment of, explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the carrier to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion, unless the individual meets the criteria specified in paragraph (1), (2), or (3).

(5) The individual is an employee or dependent who meets the criteria described in paragraph (1) and was under a COBRA continuation provision and the coverage under that provision has been exhausted. For purposes of this section, the definition of ''COBRA'' set forth in subdivision (e) of Section 10116.5 shall apply.

(6) The individual is a dependent of an enrolled eligible employee who has lost or will lose his or her no share-of-cost Medi-Cal coverage and requests enrollment within 30 days of notification of this loss of coverage.

(c) ''Preexisting condition provision'' means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to a condition for which medical advice, diagnosis,

care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(d) ''Creditable coverage'' means:

(1) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital and surgical care.

(5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e)).

(11) Any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

(e) ''Affiliation period'' means a period that, under the terms of the health benefit plan, must expire before health care services under the plan become effective.

(f) ''Waivered condition'' means a contract provision that excludes coverage for charges or expenses incurred during a specified period of time for one or more specific, identified, medical conditions.

Approved _____, 2001

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Governor